Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

AMENDED MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

HOUSTON ORTHOPEDIC & SPINE HOSPITAL
5420 WEST LOOP SOUTH, STE 3600
BELLAIRE, TX 77401

Respondent Name
CENTRE INSURANCE CO

Carrier's Austin Representative Box
19

MFDR Tracking Number
M4-12-3197-02 formerly M4-12-3197-01

MFDR Date Received
June 25, 2012

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "We are submitting this Appeal. Risk Enterprise, failed to pay for implant from Spinal Elements. Cap price $7,900.00 invoice was included with the original submission. Please review the invoice. Payment in full is now due."

Amount in Dispute: $7,900.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Please see attached EOBs from CorVel. The Texas Labor Code requires reimbursement for all medical expenses to be fair and reasonable and be designed to ensure the quality of medical care and to achieve effective medical cost control. TEX. LABOR CODE Section 413.011(d). The carrier asserts that it has paid according to applicable fee guidelines and/or reduced to fair and reasonable."

Response Submitted by: Flahive, Ogden & Latson

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
February 22, 2012	Implantables on Inpatient Surgical Services	$7,900.00	$178.85

FINDINGS AND DECISION

This **amended** findings and decision supersedes all previous decisions rendered in this medical fee dispute involving the above requestor and respondent.

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 amended to be effective May 31, 2012, *37 Texas Register 3833*,applicable to medical fee dispute resolution requests filed on or after June 1, 2012, sets out the

procedures for resolving a medical fee dispute.

2. 28 Texas Administrative Code §134.404 sets out the guidelines for reimbursement of hospital facility fees for inpatient services.
3. The services in dispute were reduced/denied by the respondent with the following reason codes:

   Explanation of benefits dated March 26, 2012

   - W1 – Worker's Compensation State Fee Schedule Adj
   - Imp, W1 – Implant/DME allowance, Worker's Compensation State Fee Schedule Adj Tissel 10 ML Fibrin (1) 559.14 X 10% = 55.92 + 559.14 + 615.05
   - Imp, W1 – Implant/DME allowance, Worker's Compensation State Fee Schedule Adj DBX Putty 10CC (4) X $1,515.00 = $6,060.00 x 10% = $606.00 + $6,060.00 = $6,666.00
   - Imp, W1 – Implant/DME allowance, Worker's Compensation State Fee Schedule Adj CRSHD CAN 30CC (2) X $622.20 = $1,244.40 X 10% = $124.44 + $1,244.40 = $1,368.84
   - IMP, W1 – Implant/DME allowance, Worker's Compensation State Fee Schedule Adj MTF CANC CHIP 30CC (1) $458.15 X 10% = 45.82 = $503.97
   - IMP,W1 – Implant/DME allowance, Worker's Compensation State Fee Schedule Adj Nexgen Biologic Strips (10) $12,000.00 + $1,000.00 = $13,000.00
   - IMP, W1 – Implant/DME allowance, Worker's Compensation State Fee Schedule Adj "Per Rule 134.404 (g) the $2,000 cap for this admission has been met by other implants billed on this day. Only the Net Amount is payable
   - 16, B15 – Not All info need for Adjudication was Supplied, Procedure/Service is not paid separately No invoice for this implantable item (CRLK CAP PRICE ADD)

   Explanation of benefits dated May 14, 2012

   - 168, 193 – No additional allowance recommended, Original payment decision maintained
   - 168, 193 - No additional allowance recommended, Original payment decision maintained

     Tisseel 10ML Fibrin (1) 559.14 X 10% = 55.91 + 559.14 = 615.05
   - 168, 193 - No additional allowance recommended, Original payment decision maintained

     DBX PUTTY 10CC (40 x1, 515.00=6,060.00X10% = 606.00+6,060.00=6,666.00
   - 168, 193 - No additional allowance recommended, Original payment decision maintained

     CRSHD CANC 30CC (2) X 622.20=1,244.40 x 10% = 124.44 + 1244.40 = 1,368.84
   - 168, 193 - No additional allowance recommended, Original payment decision maintained

     MTF CANC CHIP 30CC 458.15+10%=45.82+458.15=503.97
   - 168, 193 - No additional allowance recommended, Original payment decision maintained

     NEXEGEN BIOLOCI STRIPS (10) 12,000.00 + 1,000.00 = 13,000
   - IMP, W1, W3 – Implant/DME allowance, Worker's Compensation State Fee Schedule Adj, Additional payment on appeal/resondideration

     Threaded Cap 49.17 x 10%= 4.92+49.17=54.09 – 49.16=4.93 ADDITIONAL AMOUNT DUE OF 4.93

Issues

1. Were the disputed services subject to a specific fee schedule set in a contract between the parties that complies with the requirements of Labor Code §413.011?
2. Which reimbursement calculation applies to the services in dispute?
3. What is the maximum allowable reimbursement for the services in dispute?
4. Is the requestor entitled to additional reimbursement for the disputed services?

Findings

1. 28 Texas Administrative Code §134.404(e) states that: "Except as provided in subsection (h) of this

section, regardless of billed amount, reimbursement shall be:

(1) the amount for the service that is included in a specific fee schedule set in a contract that complies with the requirements of Labor Code §413.011; or

(2) if no contracted fee schedule exists that complies with Labor Code §413.011, the maximum allowable reimbursement (MAR) amount under subsection (f) of this section, including any applicable outlier payment amounts and reimbursement for implantables."

No documentation was found to support the existence of a contractual agreement between the parties to this dispute; therefore the MAR can be established under §134.404(f).

2. §134.404(f) states that "The reimbursement calculation used for establishing the MAR shall be the Medicare facility specific amount, including outlier payment amounts, determined by applying the most recently adopted and effective Medicare Inpatient Prospective Payment System (IPPS) reimbursement formula and factors as published annually in the Federal Register. The following minimal modifications shall be applied.

   (1) The sum of the Medicare facility specific reimbursement amount and any applicable outlier payment amount shall be multiplied by:
   (A) 143 percent; unless
   (B) a facility or surgical implant provider requests separate reimbursement in accordance with subsection (g) of this section, in which case the facility specific reimbursement amount and any applicable outlier payment amount shall be multiplied by 108 percent."

   Review of the documentation finds that that the facility requested separate reimbursement for implantables, and that the payment for the Medicare facility specific reimbursement amount is not in dispute. For this reason, the requirements of subsection (g) apply and this decision only concerns the reimbursement of implantables.

3. §134.404(g) states, in pertinent part, that "(g) Implantables, when billed separately by the facility or a surgical implant provider in accordance with subsection (f)(1)(B) of this section, shall be reimbursed at the lesser of the manufacturer's invoice amount or the net amount (exclusive of rebates and discounts) plus 10 percent or $1,000 per billed item add-on, whichever is less, but not to exceed $2,000 in add-on's per admission.

   (1) A facility or surgical implant provider billing separately for an implantable shall include with the billing a certification that the amount billed represents the actual costs (net amount, exclusive of rebates and discounts) for the implantable. The certification shall include the following sentence: "I hereby certify under penalty of law that the following is the true and correct actual cost to the best of my knowledge."

Review of the documentation found supports that the following items were certified as required by (g):

Itemized Statement Rev Code or Charge Code	Itemized Statement Description	Cost Invoice Description	# Units & Cost Per Unit	Cost Invoice Amount	***Per item*** Add-on (cost +10% or $1,000 whichever is less).
278	Tisseel 10ML Fibrin	Tisseel Kit 10ML US	1 at $559.14 ea	$559.14	$615.05
278	DBX Putty 10CC	DBX Putty 10cc	4 at $1,515.00 ea	$6,060.00	$6,666.00
278	MTF Crshd Canc 30cc	Cancellous Chips 30cc	2 at $458.15 ea	$916.30	$1,007.93
278	L/TF2 Cap Price Sys	Threaded Cap	1 at $49.16 ea	$49.16	$54.08
278	Crlk Cap price sys	No Invoice provided	$0.00	$0.00	$0.00
278	MTF Canc Chip 30cc	Crushed Cancellous 30cc	1 at $622.20 ea	$622.20	$684.42
278	Nexgen Biologic Stri	2 Strip (2cc) Bi-ostetic in collagen matrix – 50mmX10mmX2	1 at $1,200.00 ea	$1200.00	$1,320.00

		mm			
278	Nexgen Biologic Stri	2 Strip (2cc) Bi-ostetic in collagen matrix – 50mmX10mmX2 mm	1 at $1,200.00 ea	$1200.00	$1,320.00
278	Nexgen Biologic Stri	2 Strip (2cc) Bi-ostetic in collagen matrix – 50mmX10mmX2 mm	1 at $1,200.00 ea	$1200.00	$1,320.00
278	Nexgen Biologic Stri	2 Strip (2cc) Bi-ostetic in collagen matrix – 50mmX10mmX2 mm	1 at $1,200.00 ea	$1200.00	$1,320.00
278	Nexgen Biologic Stri	2 Strip (2cc) Bi-ostetic in collagen matrix – 50mmX10mmX2 mm	1 at $1,200.00 ea	$1200.00	$1,320.00
278	Nexgen Biologic Stri	2 Strip (2cc) Bi-ostetic in collagen matrix – 50mmX10mmX2 mm	1 at $1,200.00 ea	$1200.00	$1,320.00
278	Nexgen Biologic Stri	2 Strip (2cc) Bi-ostetic in collagen matrix – 50mmX10mmX2 mm	1 at $1,200.00 ea	$1200.00	$1,320.00
278	Nexgen Biologic Stri	2 Strip (2cc) Bi-ostetic in collagen matrix – 50mmX10mmX2 mm	1 at $1,200.00 ea	$1200.00	$1,320.00
278	Nexgen Biologic Stri	2 Strip (2cc) Bi-ostetic in collagen matrix – 50mmX10mmX2 mm	1 at $1,200.00 ea	$1200.00	$1,320.00
278	Nexgen Biologic Stri	2 Strip (2cc) Bi-ostetic in collagen matrix – 50mmX10mmX2 mm	1 at $1,200.00 ea	$1200.00	$1,320.00

$20,206.80	$22,227.48
Total Supported Cost	**Sum of Per-Item Add-on**

The division finds that the facility supported separate reimbursement for these implantables, and that the cost invoices were certified as required. Therefore, the MAR is calculated according to §134.404(f)(1)(B).

4. The total cost for implantables from the table above is $20,206.80. The sum of the per-billed-item add-

ons exceeds the $2000 allowed by rule; for that reason, total allowable amount for implantable is $20,206.80 plus $2000, which equals $22,206.80

Therefore, the total allowable reimbursement for the services in dispute is $22,206.80. Per the explanation of benefits submitted by both the requestor and respondent, the insurance carrier issued payment in the amount of $22,027.95 for the services in dispute. Based upon the documentation submitted and the *Table of Disputed Service,* additional reimbursement in the amount of $178.85 is recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is $178.85.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $178.85 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

Authorized Signature

	Greg Arendt	4/22/13
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, effective May 31, 2012, *37 Texas Register 3833*, **applicable to disputes filed on or after June 1, 2012**.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.